IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
RECIPIENT DESIGNATION OF PROVIDER

INSTRUCTIONS:

- Use pen to fill out. Print information clearly.
- You (or your legally authorized representative) must fill out this form to let the county know who you have chosen to provide your services.
- You (or your legally authorized representative) must sign the declaration at the bottom to show that you understand and agree to all of the terms and conditions listed.
- If you have multiple providers, you must fill out a separate form for each person who will be providing services.
- The county will keep the original form and give you a copy.
- You must let the county know if you change your provider(s). You must tell the county within 10 calendar days of the change.

1. Recipient's Name:	
2. County IHSS Case #:	
3. Provider's Name:	
4. Provider's Address:	
City, State, ZIP Code:	
5. Provider's Telephone Number:	
6. Provider's Date of Birth:	
7. Provider's Gender (check box):	☐ Male ☐ Female
8. Provider's Relationship to Recipient (if any):	

RECIPIENT DECLARATION

- I DECLARE that the person named above is my choice to provide IHSS for me as authorized by the county.
- I UNDERSTAND that the above-named provider cannot be paid federal and/or state IHSS funds for any services provided to me until he/she has completed the entire provider enrollment process, which includes completing and signing the Provider Enrollment Form (SOC 426), submitting fingerprints and undergoing a criminal background check, attending a provider orientation, and signing the Provider Enrollment Agreement (SOC 846).
- I UNDERSTAND that I will be informed by the county if the person I have chosen to be my provider does not complete the provider enrollment process, or if he/she is determined ineligible to be a provider.
- **I UNDERSTAND that if I choose to receive services from this person before he/she is enrolled as a provider, or after I have been informed that he/she is ineligible, I will be responsible for paying him/her with my own money.**
- I UNDERSTAND AND AGREE that the county can provide information about my authorized services and service hours to my provider(s).

RECIPIENT'S OR LEGALLY AUTHORIZED REPRESENTATIVE'S SIGNATURE:	DATE:
PRINTED NAME:	